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A STUDY OF CHILDREN PRESENTING FEEDING PROBLEMS KNOWN TO A CHILD GUIDANCE CLINIC

A Thesis

Submitted by

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A STUDY OF CHILDREN PRESENTING FEEDING PROBLEMS KNOWN TO A CHILD GUIDANCE CLINIC

CHAPTER I

INTRODUCTION AND PURPOSE

There is nothing, perhaps, which affects all groups in society more than the nature and welfare of children, whether they are parents with direct concern for their children or citizens who are affected by delinquencies in their communities.

To guide childhood wisely and constructively, it is first of all necessary that child nature and child needs be known. The field of child psychology deals with many variables, but there are outstanding salient factors which are placed in relation to each other for the understanding of child behavior, such as physiological factors, environment, intelligence, and training.

The purpose of this thesis is to indicate factors which manifest themselves as influencing chidren presenting feeding problems. The study is made on cases handled over a period of three and one half years from January, 1937, to June, 1940, in the Habit Clinic for Child Guidance, Boston, Massachusetts, Dr. Douglas A. Thom, Director. The material is taken from careful records kept by the clinic. The schedule used for the data obtained may be found at the close of this study. All the cases referred during the above dates for feeding problems were considered, making a total of twenty-five.

To compare the factors revealed in those cases referred for feeding problems with factors manifested in problems other than feeding problems,

another group was selected. The two groups, therefore, include:

(1) an "experimental" group made up of cases referred for problems pertaining to feeding

(2) a "control" group made up of cases referred for problems other than feeding difficulties.

The "experimental" group consists of cases referred to the clinic as feeding problems, food capriciousness, food fads, feeding difficulties, vomiting, refusal to eat, poor eating habits, or a combination of these aberrations of behavior. The "control" group consists of cases referred to the clinic over the same period of time for behavior problems other than those mentioned in the"experimental" group; for example, disobedience, infantile behavior, poor school work, enuresis, thumb sucking, delayed speech, hostility, and fears.

To insure a fair and appropriate sampling for this second group, the approximate intake per month was considered, and omitting those listed as feeding problems, the middle case of every alternating month over the same period of time was selected. The cases selected for analysis of this problem were numbered twenty.

The cases under consideration in this study are taken from a child guidance clinic, the staff of which includes psychiatrists, a psychologist, and social workers. Although a clinic for child guidance is concerned primarily with the child, the family must be considered as a unit. The use of the clinical method has the limitation which involves interpretation of objective data about child and family, both of which seem to be components of diagnosis.

Established in 1921 by Dr. Douglas A. Thom, the Habit Clinic for

Child Guidance is one of the earliest child guidance clinics and its organization follows the conventional three-fold plan, the cooperation of the psychiatrist, psychologist, and social worker.

Patients come to the clinic at the suggestion of a mother, a physician, a school, a social agency, or a friend. Since the behavior of the child represents the response which that individual makes to his environment, the need for a thorough investigation of his environmental situation is most important. This part of the clinic program is carried out by a trained social worker, who because of training not only can describe environmental influences which may be affecting the child, but also can interpret to the psychiatrist an evaluation of the surrounding conditions which may be affecting the child. In order to understand the behavior of a child it is helpful to know his intellectual capacity. This part of the clinic program is handled by the psychologist, who finds out the child's mentality, his attitudes, interests, and aptitudes toward work and play. The psychiatrist from his direct personal contact with the child and the parents gathers together all available information and utilizes it in making plans for treatment. It is the function of the clinic and its staff to investigate and study the child's behavior, mental attitude and personality deviations. The purpose of such combined analysis is to understand and to help straighten out undesirable tendencies before they become a fixed part of the child's personality. There is reason to believe that a relationship exists between the emotional and conduct disorders of early life and the problems of neurotic disturbances later in life. The clientele represents a broad cross-section socially and economically, excluding only those who can afford the service of a private psychiatrist. Originally a

clinic for pre-school children, the upper age limit is now ten years. An initial interview by the social worker, which includes the taking of a social history, is followed by a clinic appointment for the child with the psychologist, and for the mother and child with the psychiatrist. Therapy may be carried on with the mother or directly with the child. The problems listed under the two groups indicate the scope of the clinic's work; cases where the primary cause is physical are ruled out.

This study attempts to present in objective terms raw material of child nature which may be helpful as a basis for sound theories of child guidance. The content of this study may be provocative of greater accuracy of thought, and may also give leads towards a wider and more accurate understanding of children.

The chief obstacles to understanding of the dynamics leading to children's feeding problems are the variations or complexity of forces acting within or upon child nature at the time of the actual conflict, and the previous experiences and interests of the child, conscious or unconscious as they may be. He learns, remembers, forms habits, likes and dislikes, and becomes conditioned in a way that cannot be explained through the present situation or the physical set-up of his environment only, but needs a consideration of his social and psychological past. Yet, in spite of this complexity, certain stimulations are so important that they almost reduce the child's reactions to a common denominator; and thus it is possible to find psychological laws that help us to understand, to forecast, and to control child behavior in certain areas. A study of feeding difficulties in children will be useful if one can come nearer the goal

of science: Understanding, Prognosis, and Control[1]. If it will be possible to show that certain feeding behavior patterns can be traced back to certain "educational behavior patterns" of the child's surroundings, the three-fold task of psychological science will be solved. One will be able to understand the child's faulty eating habits; one will be able to forecast the type of response certain "educational" parental actions produce, and finally one will have a tool to control feeding behavior. The function of this study is to contribute to a better solution of this problem.

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1 Gordon W. Allport, The Use of Personal Documents in Psychological Science (New York: Social Service Research Council, 1942), p. 191.

CHAPTER II

THE DEVELOPMENT OF A CHILD'S PERSONALITY

The problem of this thesis is the study of feeding and eating problems of children. This problem will be seen clearer against the background of the child's whole personality, and when understanding the philosophy of the author in regard to behavior problems of children. It seems to be justified therefore to leave the main issue of this paper for a short while and to devote a few pages to a more general consideration. Such a general consideration will prepare the reader for the more specific problems dealt with in this paper, and will help the author to see the problem of eating and feeding in the light of the child's personality.

Most social psychologists consider attitude not as a static entity but as a dynamic factor, changing with the personality of the child. Since the child is continually encountering new personal experiences, the effects of imitation, of ready-made attitudes of adults, propaganda, and emotional conditioning combine to mold and modify his attitudes. The resulting integration, the attitude, will vary with the child's contact with these external forces and his reaction to them.

It is futile to ask whether personality springs from within or without, or whether a behavior problem is something constitutionally given to a child or something which comes as an external pressure from things, persons, and events. Always it is a complex mixture of all these conditions and forces. The question then changes to a consideration of what forces, internal or external, or in some combination, appear to be

crucial in the child's development and behavior.

In the effort to evaluate how much is "patient" and how much is environment, one must go back to the old formula--regardless of what doctrine one follows, whether it is the doctrine of the psychoanalytical school, or the Adlerian school, or Jung--conduct is the reaction of the individual to his environment. What has been learned is that behavior in itself is not so important as the motivation back of it. In order to understand behavior it has to be explained in terms of the individual's past experience. A good deal of behavior, both in childhood and adult life, may be "motivated by unconscious forces,"[1] and if we are going to understand any particular bit of behavior it shall have to be in terms of what the individual is himself, what he has inherited, and the environmental situation to which he has been subjected.

Problems may be divided into problem children, problem phases, and the problems of children that are but symptoms of poor management or environment. Lines of divisions, of course, are never sharp and at times the problem of a child with feeding difficulties will be understood only if all three approaches are used: Individual Psychology, Psychology of development, and Psychology of the child's surrounding. A child with hysterical vomiting certainly is a problem child, and the symptom (vomiting) can only be understood as a compromise "solution" between different psychic (inner) forces. The vomiting attacks may be increased on account of a certain phase of development (poverty, for example), and besides the

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1 Sigmund Freud, The Basic Writings of Sigmund Freud (New York: The Modern Library, 1938), p. 72.

deeper meaning of the vomiting symptom and its increase in activity because of a certain phase of the growth process, there may be found also a partial explanation through a change in environment to abnormal conditions (sudden friction between parents, problems of divorce, etc.) In many cases, however, child guidance or habit clinic has to deal with a fairly completely normal child, and the way of helping such children consists in an adjustment of the environment and not of the child. Food capriciousness, hyperactivity, and stubbornness are extremely common in well adjusted children, and these can be looked upon as problems either of a normal child going through a particular phase, or as those of a child who is a normal child being subjected to abnormal environmental conditions.

The first requisite of wholesome childhood is an environment promoting physical and social development. The home is the institution that normally fulfills this function. Society at the present time accords to parents the privilege and responsibility of the care and guidance of their children. The great importance of the family lies in the fact that the persons composing it are the first human objectives of the child's interest and love.[2]

The beginnings of the child's social relationships are with adults. The first social relationships are intimately concerned with the satisfactions of biological needs, followed by differentiation and recognition of a person and interest in personal attention. The home must be considered the workshop in which the personality of the child is being developed; and

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2 W. A. White, Mental Hygiene of Childhood (Boston: Little Brown Company, 1927), p. 65.

the personalities of the parents will make up to a very large extent the mental atmosphere in which the child has to live. For the young, personality formation is a process of "building on the innate foundations by training, discipline, and information imparted to them from the cradle onwards, the best building of all being the result of favorable emotional experiences."[3]

For parental education, a somewhat incompletely oriented program for direction of children's development is hopeful under the leadership of child guidance and associations. For their main business is confined to the attempt to undo the effects of earlier adverse conditions which the child has experienced.

"What parents bring to the management of a child and thus to the molding of his personality are their own attitudes and ideas."[4] From the time the child observes anything he looks to his mother and father for care, guidance and understanding. He looks to them for fulfillment and recognition. Needless to say, parental failures and parental attitudes are without question reasons for some of the behavior problems in children. Parents have long known that early in the child's years, especially between the ages of two and three, children change from a friendly and easy compliance to behavior patterns characterized negativistic, or resistant. The usual hypothesis is that these children are finding and preserving their place in the world, or are using such behavior to secure attention

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3 William Healy, Personality in Formation and Action (New York: Norton & Company, 1938), p. 191.

4 Jessie Taft, "The Parents Relation to the Problem of Adjustment," The Child's Emotions (Chicago: University of Chicago Press, 1930), p. 395.

and other benefits. It is tremendously important, and should be recognized and appreciated, that children have a mental life even at the age of three, four and five. Ordinarily a child has confusions, anxieties, doubts, hopes, joys and fears, feelings of insecurity, and inadequacy, to get satisfaction of life, and any of these might cause him to express his concern about life in terms of asocial behavior. The child's behavior represents desires, urges, and strivings for expression.

Instances of parental attitudes that lead to behavior problems may be described as:

(1) too concentrated attention (frequently showered upon the only child, making him selfish and spoiled, leading to definite maladjustment). It is comparatively easy to understand that the mother who has to prepare meals for a group of three children will not have as much time to spare on extra preparation for one child, or will she notice as quickly if one is not eating well.

(2) inconsistent discipline where the child soon learns that if he cannot have a thing one day he may get it the next, likewise provokes disobedience.

(3) the understanding of the child's needs during its development is a definite factor influencing necessary adjustability of the child's personality growth.

It would be practically impossible to enumerate all the attitudes and failures of parents that are reflected in their children. Let it be said that every parental attitude and failure influences a child's life and leaves a permanent impression.

CHAPTER III

THE PROBLEM - ANOREXIA

The last chapter gave a general background of the child's personality and of the many factors contributing to the molding of the make-up of the child. This preparation makes it much easier to understand the specific problems of this study from point of view of the whole child and the whole family situation. This chapter will summarize the present views and the present knowledge on feeding difficulties of children (one might add: and those of parents). Such a slow approach to the study material itself helps one to make the utmost use of the findings of others, of general psychological and sociological difficulties, and to prepare oneself for the right type of questions. The past and the present chapter are of fundamental importance for the composition of the schedule of the study. The schedule is reproduced on page 53. The preliminary study helps to analyze the case material in the right direction, as we hope, and limits the scope of the problem. This chapter deals in a more general way with the problem of Anorexia.

Since one of the fundamental organic functions of the physical well being of the child is that of eating, all parents are more or less concerned when any difficulty arises in the formation of this habit. Among the abnormalities of behavior in children is anorexia, or a refusal to eat. This phenomenon of food refusal, food capriciousness, and other feeding difficulties appears frequently in children from the ages of two to five. In the majority of cases considered it seemed that the children used this device to maintain security and to receive special attention from the

parents. "A child not interested in food is certainly as functionally pathological as anyone can be. The urge to eat is as fundamental as the urge to reproduction."[1] Feeding difficulties are of at least two parts--the physical problems and the psychological problems. Once the physiological causes of loss of appetite or feeding difficulties have been eliminated, the conditions causing drama to such episodes should be eliminated. Many children find that a negativistic attitude, not only toward feeding, but toward sleeping, playing, and general obedience, is one way of claiming attention which they desire.

It is necessary to understand the scheme of apperception by which the child acts and by which he reacts to stimuli, how he responds to them, and how he uses them for his own purposes. The important thing to remember is that a single conduct manifestation has no meaning when detached from the personality as a whole, and can only be understood in connection with the rest of the human being and his environment.

> We can be helped in our search for self-understanding, if we realize that it is impossible to explain everything about us in terms of the present. So many phenomena have started in the past. To understand any adult, we must understand him as a child...To understand a child, we must understand him as an infant...To understand an infant we must understand the circumstances into which he is born and the influences under which he grows..[2]

Even though hunger is one of the strongest biological motives, some children become problems in regard to food intake, regurgitation, and food capriciousness, that is, fussiness and finickiness about food. An un-

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1 Anton J. Carlson, "Physiology of Hunger and Appetite in Relation to the Emotional Life of the Child", The Child's Emotions (Chicago; University of Chicago Press, 1930), pp. 81-90.

2 Lee Travis and Dorothy W. Baruch, Personal Problems of Everyday Life (New York: Appleton Century, 1941), p. 421.

willingness to take a sufficient amount of food may well be regarded as an extreme form of perversion. When such is the case, the first step is to look for organic cause and specific food sensitivities, and to examine the child's general physical condition. In the case of many children, feeding difficulties arise more often from a refusal to take certain food rather than to take any kind of food. When resistance to food occurs, after eliminating organic and physical difficulties, it becomes necessary to examine the habit training causes of the problem.

Apart from the fact of taste discrimination, and of appetite, the conditions underlying the establishment of eating habits are not unlike the conditions underlying other forms of learning. The general trend of findings shows that "behavior of one sort was associated with other forms of behavior."[3] Faulty habit formation may be seen in various mental traits. Temper tantrums, feeding difficulties, disobedience, and other negativistic behavior may be utilized by the younger child to receive attention and by the older child to have his own way. Habitual indulgence in this conduct may continue into adult life unless corrected early.

The first functioning of instinctive drives in the infant serves nutritive and protective ends and the mother in satisfying these basic needs establishes her functional relation to the child. In fulfilling this role she stands as a symbol of infancy. From this base the child begins to learn meaning and value. He may exercise his emerging strength to retain this first relation with all of its infantile meaning. He may

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3 Arthur T. Jersild, Child Psychology (New York: Prentice Hall, Inc. 1933), p.546.

struggle against giving up the mother as an undifferentiated part of himself, and to some degree all children actually attempt to retain that which growth requires them to give up.

From the psychological standpoint there are three stages in learning to eat: the infantile, intermediate and modified adult. These three diet periods are, of course, not clear-cut. They overlap, and with the introduction of new foods one diet period merges into the next. Food peculiarities are often developed between these stages. The transitional period is of much greater importance than at first appears. This weaning from one stage into another comes with other psychological changes, and unless it is handled with skill it may easily become a focal point for the retention of infantilisms. Parents should remember that while the child-parent relationship continues to have value for the child, it is bound to be a constantly shifting value in which the importance of the parent should normally diminish with age and maturity. Parents are prone to demand too much from a child. This can be a serious life-long drain which only adds to inner nervousness and feelings of guilt. Children having little genuine emotional affection for their parents are quite natural and healthy in this respect. The healthy child is the child free enough emotionally to turn part of his love interest outside the home.

Learning to eat takes place because there is need to be satisfied and because such satisfaction appears to the individual to lie within his power. When it does not so appear to him, he gives up and assumes some other line of activity. There may arise the question of why and how children learn about these other lines of activity. A plausible hypothesis rests the case upon the terrific need of children, rather than upon the

differences in the capacity in adults and in children. A child is small and insecure and the price of orientation with events and persons about him is an increase in knowledge. Long in advance of formal schooling he accomplishes real learning feats, which develop into habits. He builds up a small but reasonably satisfactory world about himself, and learns how to get satisfactions within it. The understanding of this motivation is vital.

> It seems desirable as a first step to determine the reliability of comparatively easy observations, before proceeding to others which obviously require greater judgment and special skill on the part of the observer. Although the short sample measures still lack many details of interest to the clinician, they are nevertheless valuable as an initial attack on the problem of securing adequate, verifiable measure of children's behavior in natural, non-laboratory situations.[4]

The responsibility of early learning lies in the child's earliest experiences with the surrounding environment and its personalities. The first social relationships are intimately concerned with the satisfaction of biological needs, followed by differentiation and recognition of a person and interest in personal attention.

The apparent cause of a development of feeding problems is that the first sign of refusal of food is given undue attention. Although it has been mentioned that faulty food habits appear in combination with other attention-getting mechanisms, it is frequently the feeding problem that arouses the anxiety which the mother displays in her visit to the

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4 E. W. Robinson and H. S. Conrad, "The Reliability of Observations of Talkativeness and Social Contact among Nursery School Children by the 'Short-time' Sample Technique", Journal of Experimental Education, 2:163, April, 1933.

clinic. Parents encourage the child's refusal to eat by displaying their anxiety and thereby making him the center of attention. They help him to form habits of regurgitation which may start from emotional excitement, and lead to the creation of an additional mechanism.

The personality of the origin of the feeding problem in the neurosis of the parent is told by Dr. Hyman S. Lippman. In a group of fifty children of pre-school age, studied at the Amherst H. Wilder Child Guidance Clinic, St. Paul, Minnesota, thirty-one children were diagnosed as neurotic, twenty-two of which presented appetite problems. "In twenty-seven of the thirty-one neurotic children, neurosis was diagnosed in one or both parents."[5]

In the analysis of adults can be followed the vicissitudes of infantile anxiety throughout life, and it may be seen how apparently unimportant childish fears survive in the anxiety states from which they suffer, influence their character, interfere with their abilities, and "often ruin their lives...fussiness over eating, lack of appetite... may later produce hysterical symptoms of the gastric tract, drug addiction, or vegeterianism, or lead to delusions of being poisoned."[6]

Dr. Washburn, psychologist at the Clinic of Child Development of Yale University, emphasizes the need for understanding the whole child and his problems before trying to give help on specific matters, such as disobedience, aggressiveness, shyness, and the like. "Insight,

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5 Hyman S. Lippman, "Treatment of the Young Child in a Child Guidance Clinic," The American Journal of Orthopsychiatry, 12:42, January, 1942.

6 Melitta Schmideberg, "Anxiety States," Psychoanalytical Review, 27:317, October, 1940.

not formulas, make for successful training of children."[7] For symptoms are indicative not so much of disease, except by implication, as of a healing process; they are the products of an attempt to heal an underlying disease, the motive.

In all of life, and particularly during the early period, responses are constantly being conditioned by the association of chance events at the time of the response. Therefore, there is a need for studying the meaning of any type of behavior. In fact, the fundamental questions to be asked about any behavior, whether it be normal or abnormal, are: What is the meaning of this behavior? What need or urge does it satisfy in the child? Has it any possible future unpleasant significance?

In July, 1939, an article called "Anorexia Nervosa" was published in which anorexia nervosa was described as a "mechanism connecting personality disorders with somatic function."[8] Whether for lack of appetite or a compulsion neurosis, the intake of food was reduced. The authors claim that

> ...anorexia nervosa is a neurosis with compulsive, obsessive, anxiety and depressive features...Physical findings included emaciation, dry, scaly skin, cold bluish extremities, amenorrhea, atrophic type of vaginal smear, subnormal temperature, slow pulse and low blood pressure. Common personality characteristics were stubborness, meticulousness, parsimony, ambitiousness, seclusiveness, shyness, dependence on others, and difficulty in making friends.[9]

Successful treatment of anorexia nervosa was reported by T. A.

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7 Ruth Wendell Washburn, Children Have Their Reasons (New York: Appleton-Century Company, 1942) p. 10.

8 Lincoln Rahman, Henry B. Richardson and Herbert S. Ripley, "Anorexia Nervosa," Psychosomatic Medicine, 1:335, July, 1939.

9 Ibid., p. 335.

Ross [10] who recommended that the patients get away from the home situation, institute a regular regime, keep occupied, and keep from dwelling on their obsessions.

The presence of anxiety reactions and emotional conflicts in the enviroment situation are factors to keep in mind. The significant fact in the condition of anorexia nervosa is that it often does not manifest itself until the age of puberty with the emotional turmoil and the physiological adjustments that take place at that time.

Considering that a neurosis is a compromise with a motivating force engendered either by fact or fancy, that is, a mechanism used to protect one's loss of satisfaction, diagnosis of behavior problems is of prime importance.

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10 T. A. Ross, An Enquiry into Prognosis in the Neuroses (Cambridge: Cambridge University Press, 1936),

CHAPTER IV

COMPARISONS AND FINDINGS ABOUT THE CHILD IN BOTH GROUPS STUDIED

In an attempt to discover contributing causes or factors in feeding problems, the data gathered in both the experimental and control groups were tabulated according to age and sex, and intelligence quotients. The next chapter contains an analysis of data gathered from the material according to compound or natural households, parental relationship and parental attitudes. When discussing the tables, case material as illustration will be used.

Table I

Age and Sex Distribution of Both Groups

Ages (in years)	Experimental Group		Control Group		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
1	1	2	-	-	1	2
2	5	2	1	-	6	2
3	1	2	1	-	2	2
4	2	4	2	1	4	5
5	1	1	3	1	4	2
6	-	1	1	1	1	2
7	-	1	1	-	1	1
8	1	1	1	3	2	4
9	-	-	2	2	2	2
Total	11	14	12	8	23	22

Table I indicates that there is a slightly higher range in the ages of the control group than of the experimental group. The median age of the experimental group was 4.0, while the median age of the

control group was 6.75.

There were more boys referred in the control group (60%) than there were referred in the experimental group (44%). These findings seem to indicate that feeding problems occur at a slightly earlier age than other problems referred to the clinic. Another way of looking at the situation will help in understanding that parents when looking for help at a guidance clinic are motivated less by the child's actual difficulties than by their anxieties about it. A careful study of the reactions of mothers in the cases used in the analysis reveals that parents, and particularly mothers, are disturbed much earlier about feeding difficulties than about other symptoms of abnormal child behavior. One can only regret that the case studies do not reveal too much about the mother's own attitude towards eating. Her own feeding education and her own difficulties in childhood certainly must influence--consciously and unconsciously--her dealing with the food problems of her own child. Many mothers will neglect, perhaps, feeding difficulties and not try to get expert advice and help, whereas the mothers referred to in our study came as one might suspect on account of their own emotional make-up.

Since feeding difficulties were usually not as outstanding or disturbing forms of behavior as those which might lead to delinquent behavior, girls may seek the satisfaction of gaining attention by substituting food capriciousness for the accepted overt behavior of the boys. This might be the reason that girls tend more to express their adjustment difficulties in food difficulties. The popular belief that the fathers prefer the daughters, whereas the mothers like their

sons more, has been substantiated by the findings of psychoanalysis, that mothers have a rather ambivalent attitude towards their daughters.[1] The mother, on the other hand, is the little girl's educator as far as feeding is concerned. Mothers, therefore, might tend to be less tolerant in the feeding education of their little daughters than in that of their sons. Parents also are willing to allow their little boys to be "rough," whereas little girls have to find more passive outlets for instinctual gratifications.[2] Karen Horney, in "New Ways of Psychoanalysis," has re-emphasized the discovery of Freud and other psychoanalyists that our present culture is largely responsible for certain behavior patterns and character traits. One cannot understand the fact that girls, when getting into difficulties, often show symptoms different from those of the boys, without understanding that our present culture requires a totally different adjustment of boy and girl. Feeding difficulties, as any other essential problem, can only be understood if the factor of culture is considered too.

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1 Sigmund Freud, General Introduction to Psychoanalysis (New York: Liveright Publishing Corporation, 1935), p. 292.

2 Karen Horney, New Ways of Psychoanalysis (New York: W. W. Norton, 1939).

Table II

Intelligence Quotients Distribution in Both Groups

Intelligence Quotients	Experimental Group		Control Group		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
150-159	-	-	-	1	-	1
140-149	1	-	2	-	3	-
130-139	2	-	-	-	2	-
120-129	2	5	1	2	3	7
110-119	1	1	1	3	2	4
100-109	1	4	3	-	4	4
90- 99	-	1	-	-	-	1
80- 89	-	-	3	1	3	1
Superior rating	1	1	-	-	1	1
Inferior rating	-	-	1	1	1	1
Undetermined	3	2	1	0	4	2
Total	11	14	12	8	23	22

Table II indicated a slight difference in the I. Q. range in both groups. The I. Q.'s of the experimental group did not go as high or as low as the control group. This may be accounted for by the variance of the ages in the groups. There was little significance between the I. Q.'s in the boys and the girls as can be seen in the column labeled Total. The number of children having I.Q.'s of 100 or over were as follows: 68% in the experimental group and 65% in the control group. Considering the number of cases in both groups this difference is rather insignificant. Ackerson, in a study made of case material at the Illinois Institute for Juvenile Research, concluded that

> ...the influence of the age and intelligence factors on children's personality and conduct problems, while substantial, is not high...Obviously many other constant factors in addition to age and intelligence contribute

greatly to children's behavior patterns.[2]

It seems obvious that the study of intelligence quotients of the children does not help to find causes for eating difficulties. The measurement of intelligence might have more importance as far as control of the problem is concerned. Expressive treatment[3] is not possible with children (and adults) if the intelligence of the client is low. One can express this, perhaps, better in the dynamic language of psychoanalysis: the treatment of id and superego conflicts is possible only if the ego is sufficiently strong. Intelligence is an important part of ego strength. Re-education or Psychotherapy seems to have more chances for success if one can rely on a strong and intelligent ego.

Table III
Status of Child in Family

Status of Child	Experimental Group		Control Group	
	Boys	Girls	Boys	Girls
Only child	9	1	5	-
Oldest	1	5	3	4
Middle	0	1	4	0
Youngest	1	7	1	3
Favorite of father	0	1	0	0
Favorite of mother	0	0	1	0
Illegitimate	0	0	1	0
Adopted	0	0	0	0
Foster	0	0	0	0
Stepchild	0	0	0	0
Rejected by father	0	0	0	0
Rejected by mother	0	2	0	0

2 Luton Ackerson, Children's Behavior Problems: Statistical Study Based upon 5000 Children Examined at the Illinois Institute for Juvenile Research (Chicago, Illinois: University of Chicago Press, 1931), p. 255.

3 Freud, Basic Writings of Sigmund Freud, p. 366.

Most of the boys who suffered (or made their parents suffer) from eating difficulties are "only children." In this study, there were 40% "only children" in the experimental group and 25% "only children" in the control group. An only child is cared for with great anxiety and a great amount of attention is given to the problem of food which obviously has to do with the child's physical well being. Could one make the following assumptions? Mothers like boys very often too much, particularly if they are only children. The response of the overprotected child is a feeding difficulty. Mothers very often feel "ambivalent towards their daughters."[4] Conscious or unconscious rejection is "answered" with feeding difficulty.

Table III does not reveal too much. Case records are based on actual case work contacts. Such contacts cannot give as much and complete material as an artificial research situation could give. The material reveals that two mothers rejected their little daughters who answered with eating difficulties. One may assume, however, that there are more mothers who reject their children. Some of them do not express their rejection because they are ashamed of it and do not wish to admit it, and others might reject their children without knowing it. Short contacts do not reveal, as a rule, unconscious hates. It is interesting to note that one girl is the favorite of the father. The mother of this little girl rejected the child just for this reason. This is the conflict, made conscious, which is found very often in family make-ups, as

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4 Ibid., p. 301

was mentioned earlier. Rivalry situations create difficulties between mother and female child, and very often the girl will unconsciously try to hurt the mother where it hurts most. The mother who feels ambivalent toward the child must feel particularly guilty about feeding difficulties because she makes a conscious effort to care well for the child whom she unconsciously dislikes.

The comparison of the experimental group with the control group does not lead to any conclusions. The reason is to be found in the fact that the relatively small number of cases in both groups and the great number of items in regard to the status of the child within the family setting do not allow statistical conclusions. Statistics has its limitations. This can be shown also in the following table derived from the case material.

Table IV

The Type of Feeding Difficulty

Type	Girls	Boys
Refusal to eat	0	6
Refusal to eat solids	1	1
Refusal to eat liquids	0	0
Refusal to eat certain foods food capriciousness	2	2
Poor eater (slow and little)	9	1
Vomiting	2	1

Boys, as it seems, display a more aggressive behavior even in their eating difficulties. They refuse to eat, whereas, girls are poor eaters. The difference in wording certainly is rather vague, but mirrors a difference in attitude of the child. The wording is taken from the parent's report and refers merely to a psychological fact. A greater

number of cases might reveal that girls vomit more frequently than boys. Such a "hunch" cannot be proved through this study. The rather frequent case of the child's refusal to eat solids might have to do with the process of weaning. If weaning is done in an unhealthy way, too early or too late, or on account of the mother's rejecting attitude towards the child, much harm can be done. There can be no doubt that the feeding problems very often have to do with the problem of "bottle fed or breast fed" as is indicated in the following table.

Table V

Distribution of Bottle Feeding and Breast Feeding

Type of Feeding	Experimental Group			Control Group		
	Boys	Girls	Total	Boys	Girls	Total
Breast fed	3	6	9	3	1	4
Bottle fed	8	8	16	7	6	13

The comparison between experimental group and control group does not help us any further. However, one might be inclined to suspect that the greater number of bottle-fed children has something to do with their being adjustment problems. Do bottle-fed children receive less love than breast-fed children? Do mothers who chose to use the bottle quite often reject their children? The table does not reveal if the child was weaned very early and the breast replaced through the bottle. In this study there are at least five children (as the record reveals it) who were weaned after two or four months. This group could be added to the bottle-fed children who display feeding symptoms and then the discrepancy between the number of breast-fed children and bottle-fed children would be much

greater. Now one would count four (totally) breast-fed children and twenty-one bottle-fed children (some of them partially breast-fed). Such a supposition is in accordance with the opinions of physicians, psychologists, psychiatrists, and social workers who always advise mothers to breast-feed their children if there is no physical reason to prevent them from breast-feeding.

The comparisons, findings, conclusions, and discussion contributions in this chapter were derived from data about the child in both groups studied. A study is incomplete, however, if the social aspect is neglected. The child does not live as an isolated individual but is a part of a family unit. A fuller understanding of the child's eating habits and eating difficulties can only be gained if the interest of research turns to the parents, to social standards and economic problems also. The next chapter will discuss some of the problems as they emerge from our case material and study material.

CHAPTER V

COMPARISONS AND FINDINGS ABOUT THE CHILD'S FAMILY AND OTHER SOCIAL COMPONENTS IN BOTH GROUPS STUDIED

It was emphasized in this study's last chapter that the analysis of the child's "milieu" is of the utmost importance if one wishes to gain insight into the motivating factors of eating problems of children and other difficulties as well. In order to counterbalance the one-sided view that the "milieu is everything," it seems necessary to call the reader's attention to the fact that very often children answer the same stimuli as they come from their "milieu" with different reactions. This helps one to understand that the social viewpoint is but one way to look at the problem, and research has to return after the social study to the psychological make-up of the particular child. It is, of course, clear that a part of the analysis of the "milieu" of the child consists in understanding the psychological make-up of the parents, of the child's siblings, of the members of the compound family setup, and other persons in the household, perhaps even school or nursery teachers as well. With this in mind the reader should be well prepared to enter into a discussion of the findings of our study of the "milieu" of our 45 cases in experimental group and in control group.

The first table deals with the economic status of the families in both groups.

TABLE VI

The Economic Status of the Families in Both Groups

Status	Number of Families		
	Experimental Group	Control Group	Total
Depdendent	3	11	14
Marginal	10	3	13
Comfortable	12	5	17
Unknown	-	1	1
Total	25	20	45

In Table VI the families considered "dependent" were those families receiving aid; "marginal" were those families whose income met their budget for the necessities of life; and the "comfortable" families were those which suffered no financial strain.

It seems significant that fifty-five per cent of the families in the control group were dependent, while only twelve per cent of the families in the experimental group were dependent. A large difference was also noticeable in the marginal and comfortable classes. Fifteen per cent of the families in the control group were in the marginal class, while forty per cent of the families in the experimental group were in this class. Twenty-five per cent of the families in the control group were in the comfortable class, while forty-eight per cent in the experimental group were in this class. These findings seem to indicate that perhaps those families which were preoccupied and concerned about budget and "making ends meet" had less time to spend on what kind of food or how much food a child would consume, and were largely concerned with having food to

serve, let alone trying to induce or coax a child to eat.

This last conclusion seems to tempt one to assume that children of families above the lower income brackets are in a greater danger of eating difficulties. A poor child, thus, has more chances to adjust to adult food habits. Such a result should be comforting to poor people. The distressed rich parents might find some comfort in the fact, as this study indicates, that the children of the poor develop also undesirable habits, though different ones. One might suspect that well-to-do mothers very often had a comfortable childhood themselves and their own food habits might reflect on those of their children. The child's food habits have a great deal to do with the process of identification. Parents who have a normal attitude towards eating are better objects of identification than parents whose attitude toward food is not normal. Mothers in comfortable economic circumstances do not work and have more time to spend with their children, and perhaps also much more interest, whereas the poorer groups have not sufficient time and interest to center around the child's food problem. But, all this does not seem to be sufficient proof that poorer children do not develop as much eating difficulties as the children of well-to-do parents. The geographical situation of the Habit Clinic might have something to do with the selection of clients. Poorer clients might only come when "something serious" happened to the child, and might not consider food difficulties as sufficiently serious.

TABLE VII

Number of Families in Both Study Groups Having Compound Households

Nature of Family	Experimental Group	Control Group	Total
Compound Households	14	7	21
Normal Family Groups	11	12	23
Unknown	0	1	1
Total	25	20	45

Table VII indicated that the factor of compound households, (grandparents, uncles and aunts, other relatives living with the family) influenced the aberrative behavior of early life habit formation which is accompanied by other psychological learning processes, as was discussed in Chapter II. In the experimental group, fifty-six per cent of the families were of a compound nature. In the control group, in only thirty-five per cent of the families were other relatives in the home. This may be a contributing factor to the interference in disciplinary measures in the child's personality development when he seeks security from the power of the constancy of the parent or parents, only to have his confidence shattered by surrounding personalities dividing or distracting his learning process.

> Emotional states markedly interfere with the appetite. They play havoc with the child even more than with the adult... Emotional disturbances amongst the elders of the household are readily transmitted to the sensitive child.[1]

1 I. Newton Kugelmass, Growing Superior Children (New York: Appleton Century, 1935), p. 40.

The compound family is interesting for another reason too. The normal human being outgrows emotional and physical dependency from his parents and starts his own family. In most of the cases children will try to establish their own home where they can live in considerable independence. Some children, boys or girls, as they grow up into men and women, are not able to gain even their physical independence. Their parents still support them. There are others, and our study indicates quite a number of cases which are able to take care of themselves. They are not physically disabled, they can make a living, but they did not outgrow their emotional childhood ties with the parents. They still need the advice and the presence of the parent, and wish to be dominated as in the old days of childhood security. This, of course, is true also of the parents themselves. The normal parent will help the child to outgrow old family ties, and in spite of the painful process of losing the children he will understand and resign and be satisfied with the deep affectionate relationship that can exist between parents and their grown-up, physically and emotionally mature children. Some of the parents, however, do everything possible to keep their children emotionally and even physically dependent on account of their own satisfaction derived from such an "eternal parenthood."

A compound household should be sufficient reason for the case worker or psychiatrist to pay considerable attention to the problem of the relationship of the child's parents and grandparents. "Interference in disciplinary measures" might be a symptom of deeper conflicts between the child's mother and the maternal grandmother, as it was in one of the cases of this study. Different disciplinary measures might represent the

conflict between the grandmother and her daughter, the child's mother. The grandmother strives to dominate her child and thus undoes the educational actions of her daughter who still might try to succeed in gaining her emotional grown-up independence. Such conflicts are very often unconscious, and the child client with food difficulties may be but the innocent and suffering battleground of the conscious and unconscious fight between mother and grandmother. Such situations often are complicated because such an unhealthy mother-daughter relationship concerns the father of the child-client too. He might have resistance against the interference of his mother-in-law and create further difficulties in the life of the child.

But why should such a situation concern food difficulties more than other behavior problems? Eating is connected with instinctual (oral) gratifications which play an important part in the early life of the infant. Food and eating constitute an important part of the infant's early dependency. Drinking and eating therefore will play an important part in the "weapons" used in such a psychological battle for dependency and independence. Emotional dependency will express itself very often in food disturbances that are so closely connected with the oral and anal strivings of the infant and those repressed ones of his parents and grandparents. The issue of discipline which can be understood only as an expression of the different emotional make-up of parents, or as a conflict between parents and in-laws affects eating difficulties very much as can be shown in the next table also.

Table VIII

The Number of Homes with Parental Compatibility

Parental Compatibility	Experimental Group	Control Group	Total
Quarrels over money	3	7	10
Interfering relatives	8	6	14
Oversolicitous parent(s)	7*	6*	13*
Conflicting ideas of discipline	9	10	19
No friction at home	2	1	3
Unknown	1	2	3

*This factor was found to overlap with the other contributing factors in the majority of cases.

From Table VIII it is evident in comparing the findings in both groups, the issue of discipline ranked higher than any other factor examined. The number of homes in which this factor was associated with the problem was marked. The term discipline described the means of punishment or reward for behavior; oversolicitous parents were those parents who sought to over-protect the child when punishment or reward were due, i. e.,,to coddle or spoil the child with overindulgence of kindness and laissez faire management. The term "interfering relatives" warrants some notice. The percentage of influence which this factor shows might be explained along with that of discipline, since in compound households, the child's struggle to fulfill instinctive strivings meets with additional environmental personalities who enlarge the audience for performance and challenge the ingenuity of the child and persons involved.

> From any and every point of view there was ample evidence that the factor of incompatibility in marriage is one of the most injurious factors in the life of the children. Children may be too little to understand, but they are never too young to absorb emotional attitudes.[2]

Conflicts between the parents of the child-client have much to do with the eating difficulties of the child. It should not be overlooked that such conflicts very often are but an expression of the unadjusted parent. Conflicts to be understood have to be considered as symptoms. A removal of conflict that seemed to create the eating disturbance can only be done if the cause of the conflict is recognized. The case material studied reveals that many mothers did "not cooperate" and interrupted treatment of the child, or else did not accept the therapist's offer of help and interpretation. Habit clinics will be more successful if the attempt is made more often to treat the mother or other adults comprising the surroundings of the child-client. "Non-cooperation" of the mother cannot be understood without taking the mother as a person with inner conflicts and tensions. Conflicts are often of an unconscious nature, and therapy based on mere information must fail.

Therapists who consider as a reason for the failure of treatment "non-cooperation" seek for too easy an explanation. The following data from this study substantiate the last discussion points. From twenty-five cases of the experimental group four mothers refused cooperation and stopped coming after one appointment. These mothers were not interested in home visits either. Three mothers were willing to cooperate but

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2 David Seabury, Growing into Life (New York: Boni and Liveright, 1928), p. 90.

did not want to attend the clinic. One mother was not "sufficiently interested" to keep up her appointments. One mother could not come to the clinic for physical reasons (illness). Eight mothers were willing to cooperate but were unable to help. It is reported that some of the fathers showed no interest in the feeding problem of their child. But not sufficient material about the willingness of the fathers to cooperate is available. This means that for one reason or another seventeen mothers out of twenty-five were not really cooperative. Habit clinic workers should pay a considerable amount of attention to this problem. Interesting is the fact that some mothers (three)were willing to cooperate but did not want to come to the clinic. Perhaps this means: "I do not want to admit that some of the responsibility is mine. I have no emotional difficulties. My child needs help. I do not need help. But I feel somewhat guilty: I accept your visits at home." One of the functions of a habit clinic is to prepare the parents wherever necessary for treatment. This function is the particular task of the social worker. One may wonder if the treatment of the parent as the most important point of attack in dealing with eating difficulties should not be done by the person trained best: the psychiatrist. "Non-cooperation" of the parent is a symptom just as the vomiting of the child. It has to be understood in terms of dynamics. Understanding is the first step to controlling a situation. One might expect that a study of the personality of the parent in the experimental group will increase the validity of our findings.

Table IX

Personality of Parents

Characteristics of Parents	Experimental Group	
	Mother	Father
Illiterate	-	-
Irresponsible	-	-
Neurotic	4	
Oversolicitous	15	3
Strict	1	-
Intelligent	23	5

One might hope that nobody will attempt to characterize feeding-problem children as such who have intelligent parents. Intelligence obviously refers to the parents' ability to understand the interpretation of the worker. Intelligence, however, is nothing but a tool of the whole personality. Intelligence is the servant of the emotional make-up of the person and can be used in any direction. Feeding problems have nothing to do with the intelligence of the child-client or the parent, at least very little. The habit clinic knows little about the fathers. In some cases the mothers complain about the over-solicitous fathers. The fathers have little contact with the clinic and its workers. The table used does not include all the fathers and mothers but only makes use of the partial information at the disposal of this study. Otherwise, one might come to the conclusion that only two out of twenty-five fathers were intelligent. It is obvious that the habit of being over-solicitous has something to do with the feeding problem of the child. Often, however, it might merely mean: "I am responsible for the child's problem. I do

not know what to do. I am over-anxious." This might well be the expression of a neurotic personality. The table indicates that only four mothers were neurotic. This refers only to those where neurotic behavior was obvious. In some of the cases studied it was obvious that the mother was more aggressive than necessary. The degree of aggressiveness of parents is of importance for the development of the child.

An analysis of this type used here tries to isolate different components and to seek in them the causes of the problem in question. Statistical analysis tempts one to believe that either the compound family, or a neurotic mother, or bottle feeding, or a new born little brother cause eating difficulties. One prefers, of course, an explanation of such simple structure as for example: "Eating difficulties of client caused by friction in the home", or "Vomiting of child caused by mother too strict". It is known, however, that feeding and eating difficulties have in most instances more partial causes. A study of statistical nature does not reveal the structure of an individual problem but refers to groups and helps to show the most frequent causes of eating disturbances of children. A few cases will illustrate the contention that eating difficulties are not caused by one factor only but are of a much more complicated structure. The cases are from this study.

1) Patient is a little five-year old Jewish boy who has been the center of his family since his birth. The mother was extremely worried about his two operations for cleft palate and harelip, and about his throat abcesses. He is a normal and happy child in school, but his feeding was always a big problem. There has been, and is, friction between the parents and also inconsistent discipline.

Physical reasons are tied up with emotional reasons. Anxiety of a not very well adjusted mother, and over-protection by the rest of the family are of considerable influence on the child's problem. Perhaps one should stress a cultural phenomenon also. Jewish parents tend to over-protect their children and much emotional interest centers around the food problem, and not for reasons of health only. Religious customs have made food rituals very important. The cultural background has its influence on emotional attitudes and on habits as well.

2) The client is a two-and-a-half-year old boy who refuses to eat, particularly solid foods. He also annoys his mother by refusing to play alone, and to sleep. His food diffuculty is but one form of his emotional dependency. He lives in a compound large family including grand-parents, aunts and uncles. Maternal relatives and mother do not get along with his father. The father's financial inadequacy is given as a reason. There was, according to the mother's information,"absolutely no discipline or training from the first." The first impression one gets is that the eating difficulty of the youngster has something to do with the parental friction and the in-laws. One wonders, however, if the mother is not perhaps emotionally dependent on her own parents, and feels also that the child's difficulties are created by too much attachment to the mother. And such "too much" is always created by a "too much" of the mother herself. This situation does not make the impression that a normal child develops eating difficulties on account of an unadjusted surrounding, but seems to indicate that the child himself has already severely suffered in his emotional make-up. Treatment of the adults alone would not be enough. The prognosis of such cases is poor, if the parents and adults in the home cannot be

straightened out.

3) The little two-and-a-half-year old girl develops eating difficulties. The mother rejects the child, and minds very much the father's affection for the child. The mother is a neurotic, melancholic type and did not want the child (which, by the way, was bottle fed). The ambivalent attitude of a neurotic mother seems to be responsible in large part for the child's failure.

In this case the psychiatrist expected that in normal surroundings the child would react normally. Otherwise, one may predict that the child would become neurotic too. Here, the treatment of the mother is the first and perhaps the only task of the clinic.

4) This patient is a six-year old girl who is very much attached to her father, who himself prefers the newborn son. The newborn brother took a great deal of parental affection from the child. The girl's response is an eating difficulty. But, there is also a compound family situation, and mother's reaction to the child's eating symptom is "extremely emotional."

Every one of these problems at random shows the complicated nature of eating problems, and this is true for other problems as well. The case material as it was compiled in this study revealed certain frequent conditions that are contributing factors to eating difficulties. Sometimes such factors are but symptoms of deeper problems within the patient or the parent. In such cases they have to be taken for signals of deeper conflicts. The results of the study material will help to watch for such contributing factors if no schematic application is tried. Case studies of such a type help in asking reasonable questions, and looking at the

individual problem with sharpened eye; they will not answer the problem of the individual case.

It seems to be important to point out a few of the other limitations of this study too. Some of them refer to the comparing of experimental groups and control groups. Both groups, of course, differ in many respects. Parents come for different conscious reasons to the clinic. One group complains of feeding (or eating) problems, the other one of behavior problems of all types. In this respect it is worthwhile to compare these two groups in order to find contributing causes for feeding disturbances. On the other hand, the complaint at the time of referral, was quite often not the only, and also not the most obvious symptom of the child. It was only the most disturbing symptom to the parent of the child; and it was most disturbing, not for objective reaons perhaps but for the emotional and cultural make-up of the parent. The children belonging to two groups might perhaps be not so different in particular cases. Perhaps the different rationalizations of the parents have something to do with the division in these two groups of feeding problems on one side, and other problems on the other side. This does not invalidate the study but may help to see more clearly that many factors contributing to feeding problems contribute to other problems as well.

The best possible group with which to compare the experimental group would have been an average normal group of children and parents where the eating habits of the children were normal. Such a control group would perhaps have shown much better which factors contribute to abnormal and which factors contribute to normal feeding behavior. One might have expected from such a comparison to understand the sick through understanding

the healthy child. Such a study would indicate clearer perhaps what parental patterns are desirable for the producing of normal feeding patterns in children.

Attention should be called also to the fact that our "theoretical prejudices" so to speak, make us look in certain areas of the child's life. The schedule is based, as was pointed out previously, on a certain general background and a certain general attitude towards children's behavior problems and feeding difficulties in particular. Research is stimulated through such an attitude, but at times one might overlook certain connections just as important as those observed and explored.

A psychological outlook, based more intensively on dynamic psychology and less on social factors, might include into observations the phantasy life of the child. One might hope, for example, that the type of day-dreaming of the child, or his dreams, or the type of play he prefers, has something to do with eating habits. Great day-dreamers might eat slowly or eat little. Day-dreaming, of course, is again a symptom of maladjustment and points in certain directions, but it is not more, and not less, a symptom of maladjustment as the "non-cooperation" of parents, or an over-protective attitude of the grandmother, or a fight for attention as we experience it so often with children who compete with newborn siblings (see the example on page 40).

The recognitions of limitations of a study do not invalidate it. The understanding of limitations helps one to ask correct questions, and to prepare oneself better for the next step in solving the problem. This study is but one step in a certain direction. An evaluation of its limitations helps one to prepare the next step.

CHAPTER VI

SUMMARY, CONCLUSIONS AND OUTLOOK

Behind problem behavior are always causes, some of which are obvious and others more subtle in nature. The most important elements in the environment of the child are those dynamic elements, the persons and their reactions and behavior to which the child must react in one way or another. It has been realized that the problem of the child can not be separated from the whole interplay of environment and family relationships, therefore this study has dealt with both these factors, as well as personal characteristics. The emotional life of the child may by and large be considered as the major causal factor contributing to the child's behavior.

> The more or less controlled emotional life of the child is a very great factor in anorexia, in the disturbances of the feeding urge and digestion, that we meet in children.[1]

The personal characteristics, such as sex, intelligence, and the environmental characteristics of family background have shown that there were slight differences between the experimental group and the control group as to the type of problem which arose. However, it was evident that the child with a feeding problem was somewhat younger than the child with other problems. In those influencing factors associated with the family background there were significant differences in the economic status of those families in which the child was referred for feeding

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1 Carlson, op. cit., p. 87

difficulties, and of those in which the child was referred for other behavior disorders. This may be due to the fact that in families where financial stress existed, the parent or parents had little choice or time to cater to a child who refused to eat or was "choosy" or finicky with his food. The economically insecure parents could not afford the variety or quantity of food which the family enjoyed in the comfortable group.

If human beings lived in an original state of nature, a child might be given freedom to work out his own needs, and interests, in his own way. But such is not the case. By reason of his immaturity, the child cannot understand the ready-made institutions and standards of civilized living.

Because of this lack of knowledge, the child must be aided to direct his development. It is meant that within a scheme of discipline outlined by his elders, the child learns more readily if the method of attack is one of cooperation rather than of compulsion. The fundamental principle of child adjustment is to foster a cooperative spirit and to build a sense of self-confidence in the child. The major need of the child is a relationship with the parents wherein the parents shall have affection for the child and shall express it in ways that the child will understand, and at the same time see the activities of the child with a sense of humor and a certain detached intelligence which will help to make of

the child a free individual with satisfactory emotional bonds.

The problem of behavior is one of human relationships. In the problem of human relationships, an important task is the easing of the tensions and anxieties of the parents. In a study of 214 referrals in the Child Guidance Clinic of the Bobs Robert Hospital of the University of Chicago Clinics,[2] it was revealed that the concern of the children was seldom noted in the physician's records, but in the psychiatric records the parents seemed to emphasize their concern about themselves. One-third of the parents expressed knowledge of proper methods of child rearing, but an emotional inability to put these into practice. It was decided that it is the coordination of concerns expressed to all therapists which gave the true picture.

In considering family influence, home environment should be thought of not only from the standpoint of economic status of the family, but more as to the type of parents and the influence they exert either directly or indirectly upon the children. One or both parents or other members of the family may be defective, neurotic, psychopathic, or undependable. The parents may be domineering and may unintentionally crush the individuality of the child, or they make him fearful and timid by constantly worrying about him. They may absorb the child's love and affection to the exclusion of broader and more normal interests. They may project their own thwarted ambitions upon the child. In families where problems of this kind exist, as shown in

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2 Esther Heath, The Approach to the Parent -- A Study in Social Treatment (New York: The Commonwealth Fund, 1933), p. 92.

cases studied here, the interaction of each member upon each other must affect the children as well as the adults. Any kind of maladjustment in the parent or parents makes it difficult to be objective in training or managing the child.

It is often found that a parent suffering from feelings of inferiority projects his own ungratified desires upon the child. Also, the child may be made the scapegoat of his parent's resentments against one another, or a repository of love interests that have not found a normal outlet. Under the guise of affection, the parents may encourage the child's helplessness and dependence; or the child may be trained so thoroughly to place solicitude for his parents uppermost, that his own welfare is impaired. The resulting emotional attachment may become the basis for jealousy or a desire for emotional domination, or it may serve as a focus of motive for asocial behavior. The more a child is immune to emotional fixations, the more the child and the parent will be free to exercise their special personal interests and to bear the adjustments that will be necessary when their ties are altered or broken.

> Clinic workers have realized almost from the beginning of child guidance work, that the problem child is the result of parental problems, and that intensive work with him is of little avail if the home remains a place of discord. Helping the parents to better adjustments to each other and to their own problems is the quickest way of readjusting the child.[3]

In dealing with children presenting feeding difficulties, it seems that the most prominent causal factors in this study were in regard to

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3 Ibid., p. 92

disicpline, parental compatibility, and the influence of compound households. It was not surprising to find, as might well be expected, that often there was not one causal factor, but in practically every case there appeared either one or a combination of these factors, in both groups, in the study.

The situation arising with reference to the problem of discipline is exaggerated in the compound or divided household, i. e., the inability of parents to agree on any plan of action for training the child, each one forming as the occasion arises a spontaneous judgment based entirely on an emotional reaction. Nothing does more to lessen parental authority than to have some action which a parent has decided on questioned or discussed in the presence of the child, as is usually the case in families where conflicting ideas of discipline prevail. The factor of the instability and lack of discipline of the parents with young children presenting problems at a child guidance clinic is striking. Lippman[4] says "they (parents) lack consistency of effort or judgment to deal objectively with the many problems a young child presents." Oversolicitousness and interfering relatives added to the inconsistency and instability of the discipline used with the children. Children are particularly susceptible and because they are confused and bewildered by what they do not understand, they are apt to respond with behavior that makes them problem children, from the point of view of the parent.

Aside from the fact that the discipline was unstable, inconsistent, and irregular in the majority of cases, it was also usually administered

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[4] Lippman, op. cit., p. 43.

only by the mother. This authority of the mother comes from the birth of the child when she is the sole owner of the child and feels the sole responsibility for his well-being and protection. "Children must be brought up by both fathers and mothers or they cannot be safely prepared for life."[5] The father should realize that if he is going to have a family life, he must contribute more to it than his father did. He must overcome the traditional notion that it is the mother's business to maintain the family. In other days all that the father needed to contribute was money and authority, but now he should contribute time, sympathy, and to a certain extent assistance as well.

Children coming from families of compound households faced additional personalities to whom they must adjust. This factor created and furthered opportunity to the child for attempting to gain his own ends. The percentage of compound households in the group presenting feeding difficulties was considerably higher than that in the group presenting other behavior disorders. There is also a contagiousness to emotional states. Much learning is gained through imitation. Thus, the nature of the household--whether or not fear or anger are inordinately expressed, whether there is a solid emotional tone, or an unstable emotional life--plays an important part in the personality development of the child. When grandparents are able to maintain their own home, their relationship with the grandchildren is usually a happy one, but too close contact is almost certain to bring friction. Old nerves want

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5 E. R. & G. H. Groves, Parents and Children, (Philadelphia: J. B. Lippincott Co., 1928), p. 89.

quiet; young muscles demand activity. And so the mother becomes the buffer between the old and the young and is often worn thin in the process. Though antagonism and resentment may be repressed, there is an atmosphere of tension that affects all who live in it. Many grandparents make the most of a physical infirmity so that they may hold the center of the family stage and still remain important. Children unconsciously take their attitudes from their elders, not only from what is said, but from the atmosphere created.

Psychologically, children who resort to undesirable methods of behavior, do so in order to overcome a feeling of insecurity. The fact that the child is a feeding problem is an index that he has general behavior disorders and is maladjusted in his home situation. Monosymptomatic behavior is rare in a child, but since appetite is looked upon by the layman as an index of the individual's well being, mothers become anxious and unduly concerned about the child who refuses to eat. This anxiety may be due to two reasons, fear of physical defect, or heredity in cases where some member of the family displayed similar tendencies. The attitude of the parent toward heredity perhaps finds its explanation in the fact that it relieves her of responsibility for personality defects and deviations in character, both in herself and also in the child. It is often a means of protection against criticism and an excuse for failure.

It is true that no other part of the body is so affected by emotion as the gastro-intestinal tract.

> The circulatory and respiratory systems are much affected by emotion but they do their work more efficiently and with less inconvenience to the individual when reacting to emo-

> tional situations than does the system that has to do with the digesting, assimilating, and elimination of food. Physiological research has established the fact that emotions of various kinds, such as fear, anger, or excitement, influence directly the flow of secretions that have to do with the digestion of food.[6]

Mental and physical health cannot be obtained for the child if an emotional reaction on the part of the parent arouses anger, resentment or fear in the child. Emotional display and concern on the part of the parent usually directs the child's attention to his own importance, gives him a pleasing sense of power, and suggests to him how he may use the meal hour as an attention-giving device. Parents should be mindful of this scheme and should not afford an opportunity for the child to create himself as an individual of prime importance. It is tremendously important that parents make every effort to understand the motives for the conduct of their children, for all behavior is purposeful and the motives are of fundamental import rather than the conduct itself. The child's behavior is his reaction and effort to adjust to his environment with satisfaction to his inner instinctive needs and outer worldly demands. After all, social maladjustments are more frequently due to emotional instability than to intellectual or hereditary defects. Williams[7] in attempting to trace causes of social maladjustment in children stated that the complexity of causation in different cases makes it practically impossible to illustrate a single cause by a single case.

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6 Douglas A. Thom, Everyday Problems of the Everyday Child (New York, London: Appleton Century Co., 1927), p. 64.

7 Herbert D. Williams, "Causes of Social Maladjustment in Children" (University of Iowa Studies in Psychology, #15), Psychological Monographs, 1932. 43:276-300.

Public interest in behavior, under whatever name, shows that parents are groping toward a more systematic study of the causes of behavior and the hope and possibility of a more successful fruition for the many hours of sacrifice and labor. It may be ventured to say that too many attempts at discussing parents' and children's problems and making parents feel guilty may have retarded further progress. Parent-education should have as its goal making parents more confident in their ability to act with sense and humility. Parents should realize that there can be no set of iron-clad, conclusive rules for feeding habit formation. Each child is different from every other child. Each environment differs from every other environment. It naturally follows that the diagnosis and treatment must vary.

Understanding the dynamics of behavior involves more than a recognition of the type of complexes built up and broken down at the different stages of growth. The ideal concepts for the treatment of behavior are to treat the child in his dynamic, reality environment, that is, the environment of living, changing beings, who, as personalities, make up the world of the child; and to analyze the child's behavior as the relationship between his behavior and that of those personalities and their inter-relationships. The child cannot escape from an adult-made world. No matter how great his powers, he can use them only within the field opened to him by mature authorities. However weak he may be, his efforts to make up his shortcomings are held to the lines of outlet permitted by his parents and surrounding elders. Grown people fall into the way of thinking selfishly of their own wants in determining the make-up of social life, and the half-grown child is liable to be forced to fit him-

self to circumstances that may twist his capacities and make of him a mis-shapen personality. To make possible the wholesome development of its future members, society should look to treatment and guidance of its young. Child guidance is not so much for the purpose of curing children presenting behavior problems as it is to keep well children well. Parents should be educated to consult the child guidance clinic as they consult the pediatrician. The repeated use of the clinic does not signify failure on the part of the parent or on the part of the clinic. Children's problems are no more than childhood illnesses. It is the hope of the child guidance clinic to see that the child and its parents gain and have satisfactions which conform to the group, society.

BIBLIOGRAPHY

Ackerson, Luton, Children's Behavior Problems: A Statistical Study Based upon Five Thousand Children Examined Consecutively at the Illinois Institute of Juvenile Research, Chicago: University of Chicago Press, 1931, p. 255.

Bailey, Pearce, "An Introduction to Rankian Psychology, "The Psychoanalytic Review, 22:199-204, 1935.

Blanton, Smiley, and Blanton, Margaret Gray, Child Guidance, New York-London: Century Company, 1929. Chapter 3.

Blatz, William E. and Bott, Helen, Parents and the Pre-School Child, New York: William Morrow and Company, 1929.

Carlson, Anton J., "Phsyiology of Hunger and Appetite in Relation to the Emotional Life of the Child," The Child's Emotions, Chicago: University of Chicago Press, 1930, pp. 81-90.

Eliot, A. A., "Eating Habits in Relation to Personality Development of Two and Three-year Old Children," Genetic Psychologic Monographs, 13:399-481, May, 1933.

Freud, Sigmund, The Basic Writings of Sigmund Freud, New York: The Modern Library, 1938.

_____, General Introduction to Psychoanalysis, New York: Liveright Publishing Company, 1935.

Groves, E. R. and G. H., Parents and Children, Philadelphia: J. B. Lippincott Company, 1928.

Healy, William, Personality in Formation and Action, New York: W. W. Norton, 1938.

Heath, Esther, The Approach to the Parent - A Study in Social Treatment, New York: The Commonwealth Fund, 1933.

Horney, Karen, New Ways in Psychoanalysis, New York: W. W. Norton, 1939.

Jersild, Arthur T., Child Psychology, New York: Prentice Hall Inc. , 1933.

_____, "The Constancy of Certain Behavior Patterns in Your Children," American Journal of Psychology, 45:125-129, 1933.

Kugelmass, I. Newton, Growing Superior Children, New York: Appleton-Century Company, 1935.

Levy, David, "Maternal Overprotection," Psychiatry, 2:753-767, 1939.

Lippman, Hyman, S., "Treatment of the Young Child in a Child Guidance Clinic," American Journal of Orthopsychiatry, 12:42-46, January, 1942.

Rahman, Lincoln, Richardson, Henry B. and Ripley, Herbert S., "Anorexia Nervosa," Psychosomatic Medicine, 1:335-365, July, 1939.

Robinson, E. W. and Conrad, H. S., "The Reliability of Observations of Talkativeness and Social Contact Among Nursery School Children by the Short Time Sample Technique," Journal of Experimental Education, 2:161-165, April, 1935.

Ross, T. A., An Enquiry into Prognosis in the Neuroses, Cambridge: Cambridge University Press, 1936.

Schmideberg, Melitta, "Anxiety States," Psychoanalytical Review, 27:361-382, October, 1940.

Seabury, David, Growing into Life, New York: Boni and Liveright, 1928.

Taft, Jessie, "The Parent's Relation to the Problem of Adjustment," The Child's Emotions, Chicago: Chicago University Press, 1930, p. p. 390-395.

Teagarden, Florence M., Child Psychology for Professional Workers, New York: Prentice-Hall, Inc., 1940.

Thom, Douglas A., Everyday Problems of the Everyday Child, New York: Appleton-Century Company, 1927.

Thurston, Henry W., The Dependent Child, New York: Columbia University Press, 1930.

Wandling, Arilita Roberts, Ten Behavior Problems Common with Pre-School Children, New York: House of Field, Inc., 1939.

Ward, Ann, "The Only Child - A Study of 100 Only Children referred to a Child Guidance Clinic," Smith College Studies in Social Work, 8:52-60, September, 1930.

Washburn, Ruth Wendell, Children Have Their Reasons, New York: Appleton-Century Company, 1942.

White, W. A., Mental Hygiene of Childhood, Boston: Little, Brown & Company, 1927.

Williams, Herbert D., "Causes of Social Maladjustment in Children," Psychological Monographs, University of Iowa Studies in Phsychology, 43:276-300, May, 1932.

APPENDIX

SCHEDULE

Name Sex

Age I. Q.

Race Religion

Physical Condition:

a. Defects
b. General condition

Status in Family:

a. Only child--one of sex
b. Oldest, youngest of how many
c. Favorite of which parent
d. Illegitimate
e. Adopted
f. Foster
g. Stepchild

Economic situation:

a. Dependent
b. Marginal
c. Comfortable

Home conditions:

a. Compound family
b. Friction or conflicting ideas

Discipline:

Parents:

Personality
Illiterate
Irresponsible
Neurotic
Oversolicitous
Strict
Intelligent